STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK COMMONS	7235 RIVERWALK WAY NORTH NOBLESVILLE, IN46062

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R0000	This visit was for Investigation of Complaint IN00088108. Complaint IN00088108: Substantiated. State residential deficiency related to the allegations is cited at R0006. Survey dates: April 18 & 19, 2011 Facility number: 004417 Provider number: 004417 AIM number: N/A Survey team: Debora Barth, RN Census bed type: Residential: 97 Total: 97 Census payor type: Other: 97 Total: 97 Sample: 4 This state residential finding is cited in accordance with IAC 16.2.	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 4/21/11 by Jennie Bartelt, RN.			
R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.			
	Based on observation, record review and interview, the facility failed to ensure a resident who was a danger to himself was discharged from the facility. The resident required 24 hours of nursing care to ensure his safety due to wandering	R0006	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk	05/19/2011

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	and elopement. The resident eloped without staff knowledge and was found and returned to the facility by a visitor. The deficient practice affected 1 of 4 residents reviewed related to accidents in a sample of 4. (Resident A) Findings include: Resident A was observed sitting at a table in the dining/activity area on 4/18/11 at 1:00 p.m. and again at 3:00 p.m. He was drinking coffee at 1:00 p.m. He was painting with the assistance of CNA # 2 at 3:00 p.m. The clinical record for Resident A was reviewed on 4/18/11 at 11:15 a.m. The resident had diagnoses which included, but were not limited to: dementia, arthritis, high blood pressure, diabetes, and a history of prostate cancer. He had been admitted in December of 2010. The resident's family member had identified his nature as "very active." The resident had		Review in lieu a Post Survey Review on or after May 19, 2011.R006 Scope of Residential CareIt is the practice of this provider to establish and implement a written policy manual to ensure that resident care and facility objectives are attained.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Care plan meeting held on 5/4/11 with Residents family to review the comprehensive nursing care that is needed for resident's safety as indicated by the Indiana State Department of Health.During the care plan meeting with resident's family and General Manager it was agreed that resident will be transferred to a comprehensive care community of the families choice. General Manager will be assisting family with relocation process.To ensure residents safety 15-minute checks will be implemented until resident is discharged from community.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All memory care resident behavior-monitoring forms have been reviewed to identify any resident that is at risk for elopement/wandering as indicated by resident behaviors.Residents identified to be at risk for	

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	behaviors, recorded in the resident care notes, of wandering into other resident rooms and exit-seeking since his admission. The resident care notes, dated 3/16/11 at 8 p.m., indicated the resident was "unable to be located" in the building. The Certified Nursing Assistants (CNAs) had organized a room to room search at 7:45 p.m. All the doors were found to be secure, and all other residents accounted for. The resident was returned to the facility at 8:10 p.m. by a visitor. He had been found walking outside the building. The note also indicated no alarms had sounded from 7:45 p.m. to 8:10 p.m. and no visitors were noted leaving the unit during that time. The maintenance director changed the door security codes and fifteen minute checks were started on the resident. The resident had last been noticed in the unit at 7:45 p.m. His granddaughter had not been able to find him when she arrived shortly after 7:45 p.m.		elopement/wandering as indicated by resident behaviors during the monthly at risk meeting will be assessed using the Alzheimer's Disease/Dementia Care Unit Assessment Tool to ensure appropriate level of care is provided.What measures will be put in place or what systemic changes you will make to ensure that the deficient practice doe not recur:Per policy will continue to do prescreen evaluations to ensure resident meets level of care requirements prior to admission.Per policy residents are evaluated every 6 months to ensure appropriate level of care.Community will change keypad codes monthly.Staff members will escort visitors when entering and exiting the secured unit.Will continue to have all responsible parties review and sign the Move In and Discharge criteria for Auguste's Cottage (memory care) prior to admission.Elopement/Missing resident in-service was held on 3/17/11. This in-service will be held quarterly per policy.Behavior-monitoring in-service scheduled for 5/10/11.All resident behavior monitoring forms will be reviewed monthly during at risk meeting to ensure no other resident can be identified as an elopement risk as indicated by resident behaviors.Residents identified to be at risk for elopement/wandering as	

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	Interview with the two CNAs who had been working that night were conducted on 4/18/11 from 3:00 p.m. to 3:30 p.m. CNA # 1 indicated the resident had been gone about 20 minutes from the unit when he was returned. She indicated both CNAs were doing showers when the resident eloped and she was unable to determine how the resident might have been able to leave. CNA # 2 indicated the resident had been in the courtyard earlier in the evening. She remembered because she gave him a banana when he came back into the facility. She had gone to the church next door to see if the resident was there. He was not there. She was unable to determine how the resident had been able to leave, but thought perhaps he had been able to guess the door code. Interview with the Clinical Director (DON), on 4/18/11 at 11:30 a.m., indicated the resident had been exit-seeking and wandering into		indicated by resident behaviors during the monthly at risk meeting will be assessed using the Alzheimer's Disease/Dementia Care Unit assessment tool to ensure appropriate level of care is provided.Memory Care Facilitator or designee will review behavior-monitoring forms 5 x a week to identify any resident that is at risk for elopement as indicated by resident behaviors.Clinical Director or designee will review the 24-hour report daily.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:All resident behavior monitoring forms will be reviewed monthly during at risk meeting to ensure no other resident can be identified as an elopement risk as indicated by resident behaviors.Residents identified to be at risk for elopement/wandering as indicated by resident behaviors during the monthly at risk meeting will be assessed using the Alzheimer's Disease/Dementia Care Unit assessment tool to ensure appropriate level of care is provided.Memory Care Facilitator or designee will review behavior-monitoring forms 5 x a week.Clinical Director or designee will review the 24-hour report daily.By what date the systemic changes will be completed:May 19, 2011	

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	other resident rooms since admission. She indicated the resident had walked 0.4 miles on a busy highway (State Road 32) or had gone across two fields. She was not sure which way he had gone. She also indicated the staff had been looking for ways to keep him busy and use his energy productively since his admission. She indicated she staffed the unit with two CNAs and a nurse on the evening shift. She indicated one CNA worked until 10 p.m. and the other worked until 8 p.m. She presented a care plan, dated 3/6/11, which indicated the following interventions to be tried: "move to a quiet area, remove him from others rooms, take him outside for some fresh air in the courtyard, toss a ball back and forth with him, sit down with him and go through a magazine or the newspaper, ask him to help you find the items in the Tupperware container of rice, ask that he help with folding the towels, sit and talk with him, show			

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	him where his room is, determine if he is hungry and provide him with a snack if he is, play a game of cards with him, be patient." The care plan had been updated on 3/17/11 to include the following: "take on scheduled walks between 1:30 p.m. and 2:00 p.m. and again between 6:30 and 7:00. If he continues to be restless in the evening take him on another walk around 8:30; provide him with the erector set or the engine model for him to work on. Once the model engine is complete let me know; between taking care of other residents check to see were (sic) (Resident's name) is; (Resident's name) son stated that he has gospel music in his room and this is soothing to him." The resident care notes, dated 3/31/11, indicated the resident had "pulled the fire alarm." The notes, dated 4/6/11, indicated he was "wandering into other resident rooms from 8 p.m. to 11:30 p.m."			

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	and "all over the facility." The notes, dated 4/15/11 at 1 a.m., indicated he hit a CNA while she was trying to do a linen change.			